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IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 453-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

IL478-2471

Print Preview

Facility Name & ID Number WILLOWS ON MAIN# 0012195 Report Period Beginning: 7/01/1999 Ending: 6/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>18,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>45</u>	Intermediate (ICF)	<u>45</u>	<u>16,425</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,199</u>	<u>9,744</u>	<u>2,574</u>	<u>17,517</u>	8
9	SNF/PED					9
10	ICF	<u>6,869</u>	<u>8,550</u>	<u>0</u>	<u>15,419</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,068</u>	<u>18,294</u>	<u>2,574</u>	<u>32,936</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.03%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

noneF. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 5/01/71

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 29 and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAU ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6-30-00 Fiscal Year: 6-30-00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **WILLOWS ON MAIN** # **0012195** Report Period Beginning: **7/01/1999** Ending: **6/30/2000**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	262,062	36,404	41,344	339,810		339,810	0	339,810			1
2	Food Purchase		222,448		222,448		222,448	8,192	230,640			2
3	Housekeeping	117,986	26,061	1,265	145,312		145,312	0	145,312			3
4	Laundry	59,324	17,190		76,514		76,514	0	76,514			4
5	Heat and Other Utilities			77,794	77,794		77,794	0	77,794			5
6	Maintenance	57,121	15,289	93,292	165,702		165,702	0	165,702			6
7	Other (specify):* Human Resources	67,003	1,204	4,368	72,575		72,575	0	72,575			7
8	TOTAL General Services	563,496	318,596	218,063	1,100,155		1,100,155	8,192	1,108,347			8
	B. Health Care and Programs											
9	Medical Director	6,000		18,771	24,771		24,771	0	24,771			9
10	Nursing and Medical Records	1,618,999	144,250	221,629	1,984,878		1,984,878	188	1,985,066			10
10a	Therapy	112,127		19,641	131,768		131,768	0	131,768			10a
11	Activities							0				11
12	Social Services	124,342	2,602	12,700	139,644		139,644	0	139,644			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,861,468	146,852	272,741	2,281,061		2,281,061	188	2,281,249			16
	C. General Administration											
17	Administrative	92,846	22,047		114,893		114,893	0	114,893			17
18	Directors Fees							0				18
19	Professional Services			40,230	40,230		40,230	0	40,230			19
20	Dues, Fees, Subscriptions & Promotions			1,947	1,947		1,947	0	1,947			20
21	Clerical & General Office Expenses	122,098		7,853	129,951		129,951	0	129,951			21
22	Employee Benefits & Payroll Taxes			435,372	435,372		435,372	0	435,372			22
23	Inservice Training & Education			26,855	26,855		26,855	15,580	42,435			23
24	Travel and Seminar			8,987	8,987		8,987	0	8,987			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			16,504	16,504		16,504	0	16,504			26
27	Other (specify):*							0				27
28	TOTAL General Administration	214,944	22,047	537,748	774,739		774,739	15,580	790,319			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,639,908	487,495	1,028,552	4,155,955		4,155,955	23,960	4,179,915			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			132,504	132,504		132,504	0	132,504			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			8,625	8,625		8,625	8,625	17,250			32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			141,129	141,129		141,129	8,625	149,754			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			53,454	53,454		53,454	0	53,454			42
43	Other (specify):* Development			21,453	21,453		21,453	21,453	42,906			43
44	TOTAL Special Cost Centers			74,907	74,907		74,907	21,453	96,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,639,908	487,495	1,244,588	4,371,991	0	4,371,991	54,038	4,426,029			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number **WILLOWS ON MAIN** # **0012195** STATE OF ILLINOIS Report Period Beginning: **7/01/1999** Ending: **6/30/2000** Page 5

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	8,192	2		4
5	Telephone, TV & Radio in Resident Rooms	7,195	23		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	8,625	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	188	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	21,453	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	Nurse Aide Training for Non-Employees				28
29	Yellow Page Advertising	8,385	23		29
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 54,038		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$ 0		31
32	Donated Goods-Attach Schedule*	0		32
	Amortization of Organization &	0		
33	Pre-Operating Expense	0		33
	Adjustments for Related Organization	0		
34	Costs (Schedule VII)	4,200	19-3	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 4,200		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 58,238		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops			7,843	10	41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 7,843		47

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**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **WILLOWS ON MAIN**

**0012195** **Report Period Beginning:**

7/01/1999

Ending:

6/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	8,192	0	0	0	0	0	0	0	0	0	0	8,192	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	8,192	0	0	0	0	0	0	0	0	0	0	8,192	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	188	0	0	0	0	0	0	0	0	0	0	188	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	188	0	0	0	0	0	0	0	0	0	0	188	16
C. General Administration														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	15,580	0	0	0	0	0	0	0	0	0	0	15,580	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	15,580	0	0	0	0	0	0	0	0	0	0	15,580	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	23,960	0	0	0	0	0	0	0	0	0	0	23,960	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOWS ON MAIN

0012195

Report Period Beginning:

7/01/1999 Ending:

6/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	8,625	0	0	0	0	0	0	0	0	0	0	8,625	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,625	0	0	0	0	0	0	0	0	0	0	8,625	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	21,453	0	0	0	0	0	0	0	0	0	0	21,453	43
44	TOTAL Special Cost Centers	21,453	0	0	0	0	0	0	0	0	0	0	21,453	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	54,038	0	0	0	0	0	0	0	0	0	0	54,038	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

[Show Pgs 6A thru 6D](#)
[Show Pgs 6E thru 6I](#)
[Hide Pgs 6A thru 6I](#)

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Williams on Main	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes real management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transaction with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8
Schedule Y	Line	Cost Per General Ledger		Cost to Related Organization			Differences - Adjustments for Related Organization Cost Center
		Item	Amount	Name of Related Organization	Project or Program	Operating Cost of Related Organization	
		Management Fee	\$ 2,500	Mobile Software	10000	\$ 2,500	
	1						1
	2						2
	3						3
	4						4
	5						5
	6						6
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	273						273
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	277						277
	278						278
	279						279
	280						280
	281						

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6

Print Preview

[illegible]

Facility Name & ID Number WILLOWS ON MAIN

0012195

Report Period Beginning: 7/01/1999

Ending: 6/30/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
15	V		\$			\$	15
16	V						16
17	V						17
18	V						18
19	V						19
20	V						20
21	V						21
22	V						22
23	V						23
24	V						24
25	V						25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$			\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6A

Facility Name & ID Number WILLOWS ON MAIN # 0012195 Report Period Beginning: 7/01/1999 Ending: 6/30/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number WILLOWS ON MAIN # 0012195 Report Period Beginning: 7/01/1999 Ending: 6/30/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number

WILLOWS ON MAIN

#

0012195

Report Period Beginning: 7/01/1999

Ending:

6/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

[Print Preview](#)

Facility Name & ID Number WILLOWS ON MAIN# 0012195

Report Period Beginning:

7/01/1999Ending: 5/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
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	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Wesley Willows	x		New Building 1992	none	4-10-92	\$ 291,068	\$ 264,321	8-1-10	0	\$ 0	1	
2		x		New building consolidated	none	8-01-95	255,000	231,413	8-1-10	0	0	2	
3		x		New building 1992	none	7-15-92	150,000	150,000	8-1-10	7.5	8,625	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 696,068	\$ 645,734			\$ 8,625	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 696,068	\$ 645,734			\$ 8,625	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Print Preview

Facility Name & ID Number **WILLOWS ON MAIN**# **0012195** Report Period Beginning: **7/01/1999** Ending: **6/30/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1995	0	8
1996	0	9
1997	0	10
1998	0	11
1999	0	12

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,863 B. General Construction Type: Exterior brick Frame cement/metal Number of Stories 2

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>60,645</u>	<u>1991</u>	<u>\$ 15,073</u>	<u>1</u>
2	<u>Landscaping</u>		<u>1993</u>	<u>26,936</u>	<u>2</u>
3	TOTALS	60,645		\$ 42,009	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number WILLOWS ON MAIN

0012195

Report Period Beginning:

7/01/1999 Ending: 6/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97		1965	various	\$ 307,551	\$ 23,946	50	\$ 23,946	\$	\$ 23,946	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10				1964-73	582,148	24,544		24,544			9
11				1973	7,105	10,000		10,000			10
12				1976	1,411	10,000		10,000			11
13				1977	8,915	20,000		20,000			12
14				1978	4,990	20,000		20,000			13
15				1979	4,575	24,675		24,675			14
16				1980	528	30,000		30,000			15
17	Kitchen			1981	86,368	30,000		30,000			16
18	wiring			1982	373	30,000		30,000			17
19	electrical			1983	883	30,000		30,000			18
20	electrical and cable outlets ,magnetic locks			1986	20,232	30,000		30,000			19
21	mixing valves, magnets,doors			1987	25,974	40,000		40,000			20
22	boiler			1988	11,639	50,000		50,000			21
23	showers			1989	7,585	50,000		50,000			22
24	painting, varnishing,asbestos			1990	26,781	15,845		15,845			23
25	shower brick,roof,electrical,kitchen			1991	80,998	40,499		40,499			24
26	annex roof			1992	9,731	30,085		30,085			25
27	new addition			1993	1,266,524	30,000		30,000			26
28	boiler bottom			1994	6,230	30,000		30,000			27
29	roof windows, doors			1995	60,389	50,000		50,000			28
30	fire annunicator			1996	14,270	51,000		51,000			29
31	tile gazabo			1997	23,927	16,000		16,000			30
32	water heater, windows			1998	28,972	26,000		26,000			31
33	controls tuckpointing,nursing station,exhaust,heater			1999	66,802	160,476		160,476			32
34	nursing station call light,boiler pump,ramp,actuators			2000	48,998	88,336		88,336			33
35											34
36											35
36	TOTAL (lines 4 thru 35)				\$ 2,703,899	\$ 961,406		\$ 961,406	\$	\$ 23,946	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number **WILLOWS ON MAIN**# **0012195**

Report Period Beginning:

7/01/1999

Ending:

6/30/2000

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 729,172	\$ 550,170	\$ 550,170	\$		\$ 550,170	37
38	Current Year Purchases	27,406	27,404	44,169	16,765		44,169	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 756,578	\$ 577,574	\$ 594,339	\$ 16,765		\$ 594,339	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 1,538,980	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 1,555,745	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 16,765	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 618,285	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

[Print Preview](#)

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current
rental agreement:

Fiscal Year Ending

Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number

WILLOWS ON MAIN

#

0012195

Report Period Beginning:

7/01/1999

Ending:

6/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
							1	Licensed Occupational Therapist			hrs	\$ 0		\$	\$
2	Licensed Speech and Language Development Therapist		hrs												2
3	Licensed Recreational Therapist		hrs												3
4	Licensed Physical Therapist		hrs												4
5	Physician Care		visits												5
6	Dental Care		visits												6
7	Work Related Program		hrs												7
8	Habilitation		hrs												8
9	Pharmacy		# of prescripts												9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10
11	Academic Education		hrs												11
12	Exceptional Care Program														12
13	Other (specify):														13
14	TOTAL			\$		\$	\$		\$						14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,092	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	846,895		3
4	Supply Inventory (priced at cost)	56,954		4
5	Short-Term Investments	2,750		5
6	Prepaid Insurance	2,942		6
7	Other Prepaid Expenses	11,478		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 922,111	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	42,009		13
14	Buildings, at Historical Cost	2,703,899		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	756,578		16
17	Accumulated Depreciation (book methods)	(1,555,745)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds	889,391		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,836,132	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,758,243	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 458,244	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000		29
30	Accrued Salaries Payable	81,979		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,750		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 693,973	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	495,734		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 495,734	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,189,707	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,568,386	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,758,093	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,371,366	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,371,366	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	197,020	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 197,020	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,568,386	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number **WILLOWS ON MAIN**# **0012195**Report Period Beginning: **7/01/1999**Ending: **6/30/2000**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1		2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,363,919	1
2	Discounts and Allowances for all Levels	(648,953)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,714,966	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,376	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 362,376	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,843	13
14	Non-Patient Meals	8,192	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,035	23
	D. Non-Operating Revenue		
24	Contributions	328,924	24
25	Interest and Other Investment Income***	25,172	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 354,096	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>realized gains</u>	121,538	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 121,538	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,569,011	30

1		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 1,436,055	31
32	Health Care	2,243,109	32
33	General Administration	617,920	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	53,454	36
	D. Other Expenses (specify):		
37	<u>Development</u>	21,453	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,371,991	40
41	Income before Income Taxes (line 30 minus line 40)**	197,020	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 197,020	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number WILLOWS ON MAIN# 0012195Report Period Beginning: 7/01/1999Ending: 6/30/2000**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 50,000	\$ 24.04	1
2	Assistant Director of Nursing	2,000	2,080	37,295	17.93	2
3	Registered Nurses	6,847	7,007	109,111	15.57	3
4	Licensed Practical Nurses	29,555	30,355	553,554	18.24	4
5	Nurse Aides & Orderlies	72,574	74,334	869,038	11.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,000	6,240	112,127	17.97	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	11,120	11,440	124,342	10.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,000	2,080	22,319	10.73	14
15	Cook Helpers/Assistants	20,216	20,696	226,744	10.96	15
16	Dishwashers	2,000	2,080	13,000	6.25	16
17	Maintenance Workers	4,000	4,160	57,121	13.73	17
18	Housekeepers	14,000	14,560	117,986	8.10	18
19	Laundry	6,995	7,155	59,324	8.29	19
20	Administrator	2,000	2,080	55,000	26.44	20
21	Assistant Administrator					21
22	Other Administrative	2,000	2,080	37,846	18.20	22
23	Office Manager	2,000	2,080	22,505	10.82	23
24	Clerical	6,208	6,448	99,593	15.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	600	600	6,000	10.00	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Human Resources</u>	3,000	3,120	67,003	21.48	33
34	TOTAL (lines 1 - 33)	195,115	200,675	\$ 2,639,908 *	\$ 13.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	606	\$ 12,126	L1-C3	35
36	Medical Director	600	6,000	L9-C1	36
37	Medical Records Consultant	144	29,955	L10-C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	3,065	183,890	L10-C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,415	\$ 231,971		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	80	\$ 3,200	L10C1	50
51	Licensed Practical Nurses	1,510	37,750	L10C1	51
52	Nurse Aides	24,690	395,051	L10C1	52
53	TOTAL (lines 50 - 52)	26,280	\$ 436,001		53

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A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Toelke,Knight,Otto	Administrator	0.00%	\$ 55,000	Workers' Compensation Insurance		\$ 46,252	IDPH License Fee	\$
William Pratt	CEO	0.00%	22,496	Unemployment Compensation Insurance			Advertising: Employee Recruitment	
Terry Kurzinski	CFO	0.00%	15,350	FICA Taxes		164,032	Health Care Worker Background Check	819
				Employee Health Insurance		208,119	(Indicate # of checks performed 117)	
				Employee Meals			Subscriptions	267
				Illinois Municipal Retirement Fund (IMRF)*			Dues & fees	861
				Retirement 403b		16,969		
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
IBM,Xerox	Copy-fax		\$ 8,472			\$	Out-of-State Travel	\$
Minolta	Copy-fax		3,719					
Trace-Leonard	Typewriters		1,369					
Williams McCarthy	Attorney		3,384				In-State Travel	
Wesley Willows	Management		4,200				Cont. education	2,623
McGladrey Pullen	Auditors		5,983					
Entre	Computers		13,103					
							Seminar Expense	
							travel	5,257
							mileage	1,107
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)							line 24, col. 8)	\$ 8,987
			\$ 40,230					

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1		2		3		4		5		6		7		8		9		10		11		12		13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year																				
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005												
1			\$		\$																				
2																									
3																									
4																									
5																									
6																									
7																									
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19																									
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. eagle
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,513 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,454
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,192 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 20%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: McGladrey & Pullen The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.